DEPARTMENT OF MANAGED HEALTH CARE

Director: Shelley Rouillard ♦ (916) 324-8176 ♦ Help Center: (888) 466-2219 or www.HealthHelp.ca.gov ♦ Internet: www.dmhc.ca.gov

Created on July 1, 2000, the Department of Managed Health Care (DMHC) regulates the managed care industry in California. The creation of DMHC resulted from Governor Gray Davis's approval of AB 78 (Gallegos) (Chapter 525, Statutes of 1999), one component of a 21-bill package signed by the Governor in 1999 to reform the regulation of managed care in the state. The Department is created in Health and Safety Code section 1341; DMHC's regulations are codified in Title 28 of the California Code of Regulations (CCR).

DMHC administers the Knox-Keene Health Care Service Plan Act of 1975, Health and Safety Code section 1340 *et seq.*, which is intended to promote the delivery of health and medical care to Californians who enroll in or subscribe to services provided by a health care service plan. A "health care service plan" (health plan)—more commonly known as a health maintenance organization (HMO) or managed care organization (MCO)—is defined broadly as any person who undertakes to arrange for the provision of health care services to enrollees or members, or to pay for or reimburse any part of the cost for those services, in return for a prepaid or periodic charge paid by or on behalf of the enrollees or members. In Health and Safety Code section 1342, the legislature has expressly instructed the Department Director to ensure the continued role of the professional as the determiner of the patient's health needs; ensure that enrollees and members are educated and informed

of the benefits and services available in order to make a rational consumer choice in the marketplace; prosecute malefactors who make fraudulent solicitations or who use misrepresentations or other deceptive methods or practices; help to ensure the best possible health care for the public at the lowest possible cost by transferring the financial risk of health care from patients to providers; promote effective representation of the interests of enrollees and members; ensure the financial stability of health plans by means of proper regulatory procedures; ensure that enrollees and members receive available and accessible health and medical services rendered in a manner providing continuity of health care; and ensure that subscribers and enrollees have their grievances expeditiously and thoroughly reviewed by DMHC.

The Director of DMHC is appointed by, and serves at the pleasure of, the Governor. The Department's staff of attorneys, financial examiners, health plan analysts, physicians and other health care professionals, consumer service representatives, and support staff assist the DMHC Director in licensing and regulating more than 130 health plans in California. Licensed health plans include HMOs and other full-service health plans, as well as several categories of specialized health plans (including prepaid dental, vision, mental health, chiropractic, and pharmacy plans). DMHC-licensed health plans provide health care services to approximately 26 million California enrollees.

Created in Health and Safety Code section 1374.30 *et seq*., DMHC's independent medical review (IMR) system allows health plan enrollees to seek an independent review when medical services are denied, delayed, or otherwise limited by a plan or one of its contracting providers, based on a finding that the service is not medically necessary or appropriate. The independent reviews are conducted by expert medical organizations

independent of plans and certified by an accrediting organization, pursuant to conflict of interest provisions. An IMR determination is binding on the plan, and the Department will enforce it.

SB 260 (Speier) (Chapter 529, Statutes of 1999) added section 1347.15 to the Health and Safety Code to create the Financial Solvency Standards Board (FSSB). FSSB advises the DMHC Director on matters of financial solvency affecting the delivery of health care services, and develops and recommends financial solvency requirements and standards relating to plan operations, plan-affiliate operations and transactions, plan-provider contractual relationships, and provider-affiliate operations and transactions. Comprised of the DMHC Director and seven members appointed by the Director, FSSB also periodically monitors and reports on the implementation and results of those requirements and standards, and reviews proposed regulation changes.

DMHC houses the Help Center, which is open 24 hours a day, 365 days a year, and functions in many languages to help consumers who experience problems with their HMO. The Help Center educates consumers about their health care rights, resolves consumer complaints, helps consumers navigate and understand their coverage, and ensures access to appropriate health care services. The DMHC Help Center provides direct assistance to health care consumers through a call center and online access. DMHC is funded by assessments on its regulated health plans.

MAJOR PROJECTS

Essential Healthcare Benefits Regulation Approved by OAL

On June 27, 2017, the Office of Administrative Law (OAL) approved DMHC's proposed amendments to section 1300.67.005, Title 28 of the CCR, to establish revised essential health benefits under the federal Affordable Care Act (ACA) in California.

Enacted in 2010, the ACA required the Secretary of the U.S. Department of Health and Human Services (DHHS) to define "essential health benefits" (EHB), which are a minimum standard for health benefit coverage under ACA sections 1301 and 1302 (42 U.S.C. sections 18021 and 18022). DHHS issued guidance for state implementation of EHB in 2011; that guidance authorized each state to select a base-benchmark plan from a list of options to establish EHB particular to that state. Pursuant to those federal guidelines, the California legislature enacted AB 1453 (Monning) (Chapter 854, Statutes of 2012), which established Health and Safety Code section 1367.005; that statute established the California EHB benchmark plan by selecting the Kaiser Small Group HMO 30 plan as that plan was offered in 2012. Section 1367.005 also supplemented the base-benchmark plan by establishing requirements for pediatric dental and vision benefits and coverage of habilitative and mental health services. To comply with AB 1453, DMHC originally adopted section 1300.67.005 as an emergency regulation in July 2013; it permanently adopted that section in April 2014.

More recently, in 2015, DHHS directed states to select a new base-benchmark plan from options offered during the first quarter of 2014, and to supplement that base-benchmark as necessary to achieve coverage in all ten broad, federally defined EHB

categories (such as pediatric oral and vision care). Accordingly, the California legislature enacted SB 43 (Hernandez) (Chapter 648, Statutes of 2015) in order to define the new base-benchmark plan as the Kaiser Small Group HMO 30 as that plan was offered during the first quarter of 2014, and to update the EHB standards for rehabilitative/habilitative health care services and devices, pediatric benefits, and other EBH standards in accordance with federal law and guidance.

To comply with SB 43, DMHC adopted emergency amendments to section 1300.67.005, effective November 28, 2016; on February 10, 2017, DMHC published notice of its intent to permanently adopt these amendments without change. According to DMHC's initial statement of reasons, the amendments are necessary to interpret, implement and make specific the requirements for health plan coverage of EHB under Health and Safety Code section 1367.005, as amended by SB 43.

The newly-effective amendments to section 1300.67.005 clarify and implement the updated benchmark standard, and ensure consistency with SB 43's updated EHB standard and federal guidance regarding the provision of EHB. It also provides transparency to the public regarding the benefits that must be covered, and aims to implement the updated EHB standard in a manner that allows the Department to efficiently determine compliance. The approved amendments are identical to those approved as emergency regulations on November 28, 2016.

Public Meeting on SB 1052 (Torres)

On August 25, 2017, DMHC held a public meeting to discuss a draft of new section 1300.67.205, Title 28 of the CCR. Draft section 1300.67.205 would implement SB 1052 (Torres) (Chapter 575, Statutes of 2014), which amended section Health and Safety Code

section 1363.01 and added new section 1367.205. The latter provision requires DMHC to collaborate with the Department of Insurance (DOI) to develop—by January 1, 2017—a standard formulary template to be utilized by health plans and health insurers that provide prescription drug benefits and maintain one or more drug formularies.

Under new section 1367.205, such health plans (and insurers subject to DOI jurisdiction) must do all of the following: (1) post the formulary or formularies for each product offered by the plan on the plan's Internet website in a manner that is accessible and searchable by potential enrollees, enrollees, and providers; (2) update the formularies on a monthly basis; and (3) no later than six months after the date that a standard formulary template is developed by DMHC and DOI, the plan must use that template to display the formulary or formularies for each product offered by the plan. The template developed by DMHC and DOI must do all of the following: (1) include information on cost-sharing tiers and utilization controls, including prior authorization or step therapy requirements, for each drug covered by the product; (2) indicate any drugs on the formulary that are preferred over other drugs on the formulary; (3) include information to educate enrollees about the differences between drugs administered or provided under a health plan's medical benefit and drugs prescribed under a health plan's prescription drug benefit and about how to obtain coverage regarding drugs that are not covered under the plan's prescription drug benefit; and (4) include information to educate enrollees that health plans that provide prescription drug benefits are required to have a method for enrollees to obtain prescription drugs not listed in the health plan drug formulary if the drugs are deemed medically necessary by a clinician.

Under draft section 1300.67.205, the formulary should include a cover page, table of contents, informational section, categorical list of prescription drugs, and an index. The cover page shall include the title of the document; name of the health plan; the name of each product to which the formulary is applicable; the date the formulary was last updated; a direct website link to an electronic version of the formulary posted on health plan's public website; contact information for the plan; and a direct website link to specific instructions for locating plan-specific coverage documents that include cost sharing information applicable to prescription drugs.

The informational section shall include definitions; instructions on how to locate prescription drug in the categorical list of prescription drugs; a description of how drugs are listed; a description of the drug tiers in the formulary; a description of all utilization management restrictions that the plan imposes on prescription drug coverage; information about the differences between drugs covered under the medical benefit and drugs covered under the prescription drug benefit of the product; a notice that the health plan must make monthly updates on the formulary; an explanation that the presence of a prescription drug on the formulary does not guarantee that an enrollee will be prescribed that medication; a notice that the health plan must cover nonformulary drugs when medically necessary and a detailed description of the process for requesting coverage of a non-formulary drug; instructions on how to locate a network retail pharmacy to fill a prescription; a detailed description of the process for requesting prior authorization or an exception to a step therapy requirement; notice of an enrollee's rights concerning step therapy; notice that a health plan may not limit or exclude coverage for a drug if it was previously approved and the provider continues to prescribe the drug for the medical condition; a description of the

limit on cost sharing for orally administered anti-cancer drugs; a detailed description of the process for requesting coverage and obtaining drugs that are limited to restricted specialty pharmacy access or are subject to other network limitations (as applicable); and an annotated legend or key to all abbreviations, symbols, and notations used in the formulary.

The categorical list of prescription drugs must be organized by drug category and class based on a commonly used and widely accepted drug classification system; include a complete list of all covered prescription drugs; include columns which distinguish prescription drug name, drug tier, and coverage requirements and limits; list the proprietary name for a brand name drug in all capital letters in the "prescription drug name" column; and include all covered dosage forms and strengths for each prescription drug. The "drug tier" column should include the cost sharing tier in which the prescription drug is placed. The "coverage requirements and limits" column should include abbreviations or symbols for all utilization management restrictions that the health plan imposes on prescription drug coverage. The annotated legend or key to all abbreviations, symbols, and notations used in the formulary must appear on each page of the categorical list.

Finally, the index must list each covered brand name and generic drug by brand name in alphabetical order and include the page number for the location of the drug in the categorical list of prescription drugs.

At this writing, neither DMHC nor DOI has published proposed regulations to implement SB 1052.

Public Meetings on AB 72 (Bonta)

On June 26 and September 12, 2017, DMHC held stakeholder meetings on its proposed implementation of AB 72 (Bonta) (Chapter 492, Statutes of 2016), parts of which

took effect on July 1, 2017. AB 72 protects consumers from surprise medical bills when they go to in-network facilities, such as hospitals, labs, or imaging centers and receive non-emergency services from a non-contracted provider. Effective July 1, 2017, AB 72 enacted Health and Safety Code section 1371.9, which requires that if an enrollee receives covered health care services from an in-network facility at which, or as a result of which, the enrollee receives services from a non-contracted individual health professional, the enrollee shall pay no more than the same amount the enrollee would have paid if the health care services were received from a contracted individual health professional. Health plans were required to have this provision in their contracts on or after July 1, 2017.

AB 72 also added section 1371.31 to the Health and Safety Code, which creates—effective July 1, 2017—a default reimbursement rate for non-contracting providers, which is the greater of 125% of the Medicare rate or the "average contracted rate" (ACR). Thereafter, the new section requires DMHC—by January 1, 2019—to develop a standardized methodology for calculating the ACR paid to non-contracting providers.

Finally, AB 72 added new section 1371.30 to the Health and Safety Code, which required DMHC—by September 1, 2017—to establish an independent dispute resolution process (IDRP) for the purpose of processing and resolving a claim dispute between a health plan and a non-contracting individual health professional for services subject to section 1371.9. The bill authorizes DMHC to contract with one or more independent organizations to conduct the AB 72 IDRP, and DMHC's IDRP is conducted electronically through a web-based portal that is managed by MAXIMUS Federal Services, Inc.

DMHC has created an AB 72 Non-Emergency Services IDRP Application form and cautions that eligible claim disputes that are subject to DMHC jurisdiction under AB

72 must meet all of the following criteria: (1) the disputed claim must be for services rendered on or after July 1, 2017; (2) the disputed claim must be for non-emergency services; if there is an unresolved dispute as to whether the health care service(s) at issue is non-emergent, the claim does not qualify for the AB 72 IDRP; (3) the disputed claim must be for covered services provided at a contracting health facility, or provided as a result of covered services at a contracting health facility, by a non-contracting individual health professional; (4) the non-contracting provider has completed the health plan or payor's Provider Dispute Resolution (PDR) process within the last 365 days; (5) the non-contracting provider is not a dentist; and (6) the payor is not a Medi-Cal managed health care service plan or any other entity that enters into a contract with the State Department of Health Care Services.

At the public meetings, DMHC staff walked attendees through definitions of various terms used in AB 72 and the regulation timeline under which the Department will develop regulations containing the standardized methodology for calculating the ACR to be paid to non-contracting providers. At this writing, DMHC has not yet initiated that rulemaking process.

2016 Annual Report

On June 17, 2017, DMHC released its 2016 annual report, which includes an enrollment overview, the implementation of DMHC's Health Plan Dashboard, statistics on the Help Center, plan licensing, plan monitoring, financial oversight, rate review and enforcement against health care insurers and agents. Overall, DMHC assisted with over 164,000 phone inquiries, 14,000 consumer complaints, 5,300 independent medical review cases, and 4,819 non-jurisdictional referrals.

♦ ***Enrollment Overview***. In 2016, full service health plan enrollment was over 25 million; enrollment in specialized plans reached 30 million. Health plan enrollment has shifted from primarily commercial enrollment to more evenly distributed enrollment between commercial and government enrollment.

♦ ***Help Center and Health Plan Dashboard***. In 2016, DMHC's Help Center assisted over 188,000 health care consumers, received over 14,000 complaints, and closed over 5,000 independent medical reviews. DMHC also implemented the "Health Plan Dashboard," an online tool created to increase public accessibility to health plan information and data. The data compiled includes information on health plans licensed by DMHC, enrollment, financial reports, premium rates, consumer complaints, audit reports, and DMHC enforcement actions. The Dashboard feature also provides an overview of the health plan industry, and provides information on enrollment, financial reports, premium rates, consumer complaints, and enforcement. With these items tracked, consumers can compare their health plans to others. During 2016, frequent consumer complaints included coverage cancellation, billing problems, quality of service, coordination of care, and other coverage concerns. Most concerns are resolved through the standard complaint process. Independent medical review is available if a health plan denies, modifies, or delays a request for services as not medically necessary, experiential, or investigational.

♦ ***Plan Licensing***. DMHC issues licenses to health plans in California and reviews health plan mergers to ensure adherence with Knox-Keene Act consumer protection and financial solvency requirements. In 2016, DMHC approved the merger of Centene's acquisition of Health Net and Aetna's acquisition of Humana (later barred by the U.S. Department of Justice).

♦ ***Plan Monitoring***. The Office of Plan Monitoring (OPM) was created and implemented in 2016 to improve oversight of health plan care and delivery systems in compliance with the Knox-Keene Act. Specifically, OPM oversees access to health care, utilization management, quality improvement, continuity and coordination of care, language access, and enrollee grievance and appeals. DMHC monitors provider networks and accessibility of services to enrollees, physician-patient ratios, and compliance with its timely access to health care regulations. DMHC additionally conducted ten surveys of commercial full-service health plans as a continuation of the Paul Wellstone and Pete Domenci Mental Health Parity and Addiction Equity Act.

♦ ***Financial Oversight.*** In 2016, DMHC uncovered 230,000 unprocessed claims for services provided to consumers under the L.A. Care Health Plan. DMHC worked with L.A. Care to ensure the claims were processed by July 2016. The total amount paid to providers was $10.01 million plus an additional $900,000 in interest. This is the largest claims payment remediation resulting from a DMHC financial examination.

♦ ***Rate Review***. In 2016, DMHC reviewed 47 individual and small group rate filings. DMHC convinced Aetna Health of California, Inc. to reduce its proposed rate hike (see below) and saved small group consumers around $1.3 million.

♦ ***Enforcement.*** In 2016, DMHC took numerous enforcement actions against health plans and agents who solicit business for health care services. For example, DMHC fined Anthem Blue Cross $700,000 and ordered corrective action for improperly cancelling health coverage to 69 individuals from May 2013–December 2014.

DMHC also imposed a penalty against Kaiser Foundation Health Plan, Inc. for its refusal to approve an enrollee's request for a second opinion from an out-of-network

specialist. DMHC additionally imposed fines regarding grievance system violations to both Anthem Blue Cross ($1 million) and Kaiser Permanente ($195,000). Blue Shield of California was also awarded a fine of $125,000 for misconduct during the independent medical review process. Lastly, DMHC took enforcement action against solicitors or insurance agents who engaged in fraudulent or dishonest dealings with the public while enrolling consumers in health plan products.

Recent Enforcement Actions

Following is a description of other recent enforcement actions taken by DMHC:

♦ ***Fines against Health Net for violating antidiscrimination laws***. On July 24, 2017, DMHC issued a total of $200,000 in fines against Health Net after it discovered the plan denied health services to members of the transgender community in previous years. DMHC found that Health Net had violated antidiscrimination laws by denying coverage to several patients who attempted to obtain gender reassignment surgeries. Health Net maintained it believed the surgeries to be cosmetic and, in some cases, based the denial on exclusions or limitations in the patient's plan because of their transgender status (a violation of California's Insurance Gender Nondiscrimination Act, codified at Health and Safety Code section 1365.5).

♦ ***Kaiser Permanente's provision of behavioral health care services***. On July 18, 2017, DMHC and Kaiser Foundation Health Plan, Inc. (Kaiser Permanente) announced a settlement agreement concerning Kaiser's inadequate provision of access to mental health services, which DMHC identified in its 2015 and 2017 routine survey reports. Kaiser is expected to meet the deliverables and benchmarks outlined in the settlement agreement or be subject to a $1 million fine. Kaiser is also expected to re-work its Behavioral Health

Quality Assurance Program to mitigate accessibility issues. Kaiser will contract with an expert consultant for advice on how to improve oversight of its behavior health system. The stipulation requires Kaiser to pay for a behavioral health care consultant and, in good faith, consider their recommendations. Kaiser will be required to work with the consultant for one to three years. The corrective action plan includes improvements to documentation of Kaiser's quality improvement efforts for access compliance, improvements in transparency in behavioral health appointment access, implementation of a policy that all members who are not offered timely access to services are reviewed for risk and ensured their needs are taken care of, implementation of monitoring systems to track access of follow-up appointments, internal corrective action plan development that documents the extent of root cause analysis and corrective action interventions, and improved integration of external provider access data and oversight. Monetary fines will be imposed if Kaiser fails to meet a benchmark or deliverable.

Anthem Lowers Rate Increase in Response to DMHC

In mid-October 2017, Anthem Blue Cross agreed to lower two planned premium increases for 2018 when DMHC questioned Anthem's cost prediction. Anthem previously argued that Californians were estimated to ingest a significantly higher amount of prescription medication in 2018 and used this to justify a 30% increase in prescription drug costs for 2018. Anthem later announced it would reduce its planned premium increases for 2018 by $114,000,000.

DMHC Studying Federal Regulations Regarding Contraceptive Coverage

On October 6, 2017, DMHC issued a statement on federal regulations regarding contraception coverage. Director Shelley Rouillard stated that the DMHC is currently reviewing the details of new federal regulations and possible impacts to Californians enrolled in plans licensed by the DMHC. California has a long history of expanding timely access to birth control to prevent unintended pregnancy, and has enacted laws that promote gender equity and women's health. State-regulated health plans must cover contraceptives for women without cost sharing, with very few exceptions offered for religious employers as defined in California law. Hundreds of thousands of women throughout the United States are eligible to receive most methods of birth control at no cost under the Affordable Care Act's essential health benefits requirement. However, the Trump Administration's executive order signed October 12, 2017 expands the number of employers and insurers that qualify for exemptions from the requirement of having to provide birth control by asserting a religious or moral objection.

LEGISLATION

SB 223 (Atkins), as amended September 5, 2017, amends section 1367.04 and adds section 1367.042 to the Health and Safety Code regarding language assistance services and qualifications for interpreters provided by health plans to enrollees with limited English proficiency (LEP).

Amended section 1367.04 requires health plans to provide written notice in specified documents of the availability of interpretation services in the top fifteen

languages spoken by LEP individuals in California, identified annually as determined by the Department of Health Care Services. The amendments to section 1367.04 require interpreters to have demonstrated proficiency in English and the target language, and knowledge in both English and the target language of health care terminology and concepts relevant to health care delivery systems. Additionally, an interpreter must adhere to generally accepted interpreter ethics and principles, including client confidentiality. The amendments also prohibit an enrollee from being required to provide his/her own interpreter, rely on an adult or minor child for interpretation services, or rely on a staff members who does not meet the new requirements for interpreters.

New section 1367.042 requires health plans to notify enrollees and members of the public of all of the following information: (1) the availability of language assistance services, including oral interpretation and translated written materials, and how to access these services free of charge and in a timely manner; (2) the availability of appropriate auxiliary aids and services, including qualified interpreters for individuals with disabilities and information in alternate formats; (3) the health plan does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identify, sexual orientation, age, or disability; (4) the availability of a grievance procedure, how to file a grievance, and how to submit the grievance to DMHC after completing the grievance process or participating in it for at least 30 days; and (5) how to file a discrimination complaint with the DHHS Office of Civil Rights. The new section requires health plans to provide this information to enrollees upon initial enrollment and annually thereafter. The section also requires that the information be provided in a conspicuously visible location in the evidence of coverage; in or with materials that are routinely

disseminated to the plan's enrollees at least annually; and on the plan's Internet website in a manner that allows enrollees, prospective enrollees, and members of the public to easily locate the information. Governor Brown signed SB 223 on October 13, 2017 (Chapter 771, Statutes on 2017).

SB 17 (Hernandez), as amended on September 5, 2017, adds and amends numerous sections of the Health and Safety Code to promote transparency in prescription drug pricing, to enable measurement of the impact of prescription drug costs on the overall health plan premium, and to provide information on prescription drug price increases to patients, state programs, employers, and other payers.

Beginning October 1, 2018, new section 1367.245 requires health plans that report rate information to DMHC through the existing small and large group rate review process to also report annually to DMHC the following information on all covered prescription drugs: (1) the 25 most frequently prescribed drugs; (2) the 25 most costly drugs by total annual spending; and (3) the 25 drugs with the highest year-over-year increase in total annual spending. The new section also requires DMHC to compile this information into a report for the public and legislators, and—beginning January 1, 2019—to post that report on its website.

The amendments to section 1385.045 require health plans to annually report to DMHC the following information on specified prescription drugs: (1) the percentage of the premium attributable to prescription drug costs for the prior year for each category of prescription drugs; (2) the year-over-year increase, as a percentage, in per-member, per-month total health plan spending for each category of prescription drugs; (3) the year-over-year increase in per-member, per-month costs for drug prices compared to other

components of the health care premium; (4) the specialty tier formulary list; (5) the percentage of the premium attributable to prescription drugs administered in a doctor's office that are covered under the medical benefit as separate from the pharmacy benefit, if available; and (6) information on the plan's use of a pharmacy benefit manager (PBM), if any, including its name and which components of the prescription drug coverage are managed by the PBM.

SB 17 also adds new Chapter 9 (commencing with section 127675) to the Health and Safety Code, which requires manufacturers of certain prescription drugs that are purchased by state-regulated programs (including licensed health plans) to notify the state at least 90 days in advance of the planned effective date of an increase in the wholesale acquisition cost of those drugs under specified circumstances. Governor Brown signed SB 17 on October 9, 2017 (Chapter 603, Statutes on 2017).

AB 1316 (Quirk), as amended September 1, 2017, amends section 1367.3 of the Health and Safety Code to clarify the circumstances under which health plans must cover screening for lead poisoning in children. The amendments require health plans that cover hospital, medical, or surgical expenses on a group basis to cover screening for blood lead levels in children of any age who are at risk for lead poisoning if that screening is prescribed by a health care provider (including physicians, nurse practitioners, and physician assistants) affiliated with the plan. Governor Brown signed AB 1316 on October 5, 2017 (Chapter 507, Statutes of 2017).

AB 1048 (Arambula), as amended September 8, 2017, adds section 4052.10 to the Business and Professions Code to permit pharmacists—beginning July 1, 2018—to dispense a Schedule II controlled substance as a partial fill (defined as a part of a

prescription filled that is of a quantity less than the entire prescription). Additionally, the bill adds section 1367.43 to the Health and Safety Code, which requires health plans—commencing July 1, 2019—to prorate an enrollee's cost sharing for a partial fill of a prescription dispensed pursuant to Business and Professions Code section 4052.10. Section 1367.43 applies only to oral, solid dosage forms of prescription drugs. AB 1048 is intended to prevent the over prescription of opioids and minimize the number of pills available for unintentional or intentional diversion. Governor Brown signed AB 1048 on October 9, 2017 (Chapter 615, Statutes of 2017).

SB 133 (Hernandez), as amended September 12, 2017, and as it relates to DMHC, amends section 1373.96 of the Health and Safety Code to require a health plan, at the request of a newly covered enrollee under an individual health care service plan contract, to arrange for the completion of covered services as set forth in existing law by a nonparticipating provider if the newly covered enrollee's prior coverage was terminated under certain circumstances (including when a health benefit plan is withdrawn from any portion of a market). The bill also requires health plans to provide notice as to the process by which an enrollee may request completion of covered services at the time the plan sends a notice of termination of coverage notice to the enrollee. SB 133 is intended to ensure continuity of care to enrollees suffering from a serious chronic condition and whose health plan withdraws from a particular market while the enrollee is undergoing treatment. Governor Brown signed SB 133 on October 4, 2017 (Chapter 481, Statutes of 2017).

AB 1074 (Maienschein), as amended August 24, 2017, amends section 1374.73 of the Health and Safety Code, which requires health plans to provide coverage for behavioral health treatment (BHT) for pervasive developmental disorder or autism provided by a

qualified autism service professional supervised and employed by a qualified autism service provider. AB 1074 revises those provisions to require a qualified autism service professional or a qualified autism service paraprofessional to be supervised by a qualified autism service provider for purposes of providing BHT. The bill requires a qualified autism service professional and a qualified autism service paraprofessional to be employed by a qualified autism service provider or an entity or group that employs qualified autism service providers. The bill additionally authorizes a qualified autism service professional to supervise a qualified autism service paraprofessional. The bill also revises the definition of a "qualified autism service professional" to, among other things, specify that the BHT provided by the qualified autism service professional may include clinical case management and case supervision under the direction and supervision of a qualified autism service provider. According to the author, the bill is intended to update existing law relating to providers of BHT for children with autism to reflect existing practices and changes in the field, and remove unnecessary barriers and increase access to care. Governor Brown signed AB 1074 on September 30, 2017 (Chapter 385, Statutes of 2017).

SB 562 (Lara and Atkins), as amended May 26, 2017, would add Title 22.2 to the Government Code to enact "The Healthy California Act." The Healthy California Act would require a comprehensive universal single-payer health care coverage system for all Californians. The bill is not to become effective until the Secretary of Health and Human Services establish funding for the implementation of the bill.

SB 562 would require Healthy California to be governed by an unpaid executive board comprised of nine members appointed by the Governor and legislature. It would also require the executive board members to have demonstrated knowledge, evident expertise

in health care, and would require four members from a nurse labor organization, the general public, a labor organization, and the medical provider community. The bill would permit all Californians residents to be eligible and entitled to enroll. "Resident" is defined as an individual whose primary dwelling is in the state and without regard to that individual's immigration status. Enrollees of Healthy California would not be required to pay any premium, co-payments, co-insurance, deductible and any other form of cost sharing for all covered benefits.

SB 562 would require all medical care determined to be medically appropriate by the member's health care provider. This would include all services provided by Medi-Cal, essential health benefits (from the Affordable Healthcare Act), and all health plan- or insurance-mandated benefits. Benefits shall include: chiropractic, vision, dental, ancillary health or social services (previously covered by a regional center), skilled nursing facility care, and therapies shown by the National Institutes of Health, National Center for Complementary and Integrative Health to be safe and effective. *[A. Desk]*

AB 315 (Wood), as amended July 11, 2017, would add Division 121 (commencing with section 152000) to the Health and Safety Code regarding pharmacy benefit management. The new division would require pharmacy benefit managers (PBM) to register with DMHC prior to conducting business within California. DMHC would be required to develop a registration form, and would be authorized to charge a fee for registration and to suspend a registration of a PBM under specified circumstances. This bill would also require a PBM to exercise a duty of good faith and fair dealing in the performance of its contractual duties to a purchaser, and would require a PBM to disclose to a purchaser any conflict of interest that would interfere with the discharge of that duty.

The bill would require a PBM to periodically disclose to a purchaser, at the purchaser's request, certain information such as drug acquisition cost, rebates received from pharmaceutical manufacturers, and rates negotiated with pharmacies. The bill would require a PBM to notify a pharmacy network provider of certain material contract changes at least 30 days before those changes take effect, and would prohibit a PBM from notifying an individual receiving benefits through that PBM that a pharmacy has been terminated from its network until the required notice has been provided to the pharmacy. The bill would prohibit a PBM from including in a contract with a pharmacy network provider provisions that prohibit the provider from informing consumers of alternative medication options or from dispensing a certain amount of prescribed medication, as specified. The bill would apply these provisions to a contract or contractual relationship between a PBM and a purchaser or between a PBM and a pharmacy network provider that is entered into, issued, amended, renewed, or delivered on or after January 1, 2018. The bill would provide that these provisions and those relating to registration described above do not apply to a health plan, health insurer, or related entities that perform PBM services only for enrollees of the plan or insureds of the insurer. *[S. Inactive File]*

LITIGATION

On April 28, 2017, the U.S. Court of Appeals for the District of Columbia issued a permanent injunction preventing the merger of Anthem and Cigna in ***United States, et al. v. Anthem, Inc., et al.***, 855 F.3d 345 (D.C. Cir. 2017). The merger would have fused together the second and third largest national health insurance carriers. U.S. Circuit Judge Judith W. Rogers indicated the district court acted within its discretion to permanently

enjoin the merger and that Anthem failed to demonstrate the type of extraordinary efficiencies required to offset the negative impact to market competition that would result from the merger. Under section 7 of the Clayton Act, 15 U.S.C. section 18, a merger may not continue between two companies if the market or an activity that impacts the market would substantially be impacted by less competition. On May 5, 2017, Anthem submitted a petition for a writ of certiorari to the U.S. Supreme Court; the Court denied that request on June 12, 2017.

On April 25, 2017 in ***Martello v. Rouillard, et al.***, 689 Fed. Appx. 880 (9th Cir. 2017), the U.S. Ninth Circuit Court of Appeals affirmed the district court's judgment which dismissed Jeannette Martello's complaint. Dr. Martello, a licensed plastic surgeon, has a long history of unlawful balance billing practices; DMHC has secured at least two cease and desist orders against her, and a trial court imposed $562,000 in civil penalties against her in June 2013. At the time she filed the federal court complaint in this matter, she was appealing the state court's orders in the Second District Court of Appeal. In the federal court matter, Martello challenged the constitutionality of California's prohibition against balance billing. She maintained that DMHC and the Medical Board of California's (MBC) continued enforcement against her practice of balance billing is unconstitutional and is preempted by federal law. Additionally, Martello also sought a permanent injunction to enjoin DMHC and MBC from enforcing balance billing laws. Reviewed *de novo*, the Ninth Circuit found the district court properly dismissed Martello's action under the *Younger* doctrine, which states federal courts must not interfere with pending state court proceedings where the federal action would enjoin state proceedings.

Martello was previously disciplined by MBC for her balance billing practices; MBC found that she had willfully and unlawfully billed patients for emergency services, and placed her license on probation for five years.

In a June 12, 2017 unpublished decision, the Second District Court of Appeal affirmed the dismissal of Martello's claims against DMHC.